State of New Hampshire
Department of Health and Human Services
Division of Community Based Care Services
Bureau of Elderly and Adult Services

SFY 2011 Case Management Program Evaluation

Crotched Mountain Community Care

October 2010

Prepared by:

Division of Community Based Care Services
Quality Management

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Executive Summary

The Division of Community Based Care Services (DCBCS,) in its commitment to the principles and activities of quality management established a division wide quality management philosophy and infrastructure which included a Quality Leadership Team, facilitated by the Deputy Director, and which is comprised of representatives from the DCBCS bureaus. A number of performance indicators were identified that address either system performance, safety, participant safeguards, participant outcomes and satisfaction, provider capacity, or effectiveness.

One of these performance indicators was to perform annual site visits of the independent case management agencies for the purposes of assuring that the home and community based care elderly and chronically ill waiver program participants' service plans were appropriate, person-centered, that the delivery of services was timely and that the case management agencies had the capacity and capability to deliver or access the services identified in the participants' service plans. This task was subsequently included in the 2007 application for the Home and Community Based Care – Elderly and Chronically Ill waiver as a component of the quality management section of the waiver and is identified as a performance measure for several quality management assurances.

The first annual program evaluation reviews for the five independent case management agencies were completed in May and June of 2009 and were based on the Targeted Case Management Services rule, He-E 805, which was adopted effective August 26, 2008. Program evaluation protocol and a review instrument were developed by a committee that included BEAS staff and which were shared and discussed with the five licensed case management agencies that served participants in the HCBC-ECI waiver program, also known as the Choices for Independence (CFI) program.

The 2009 program evaluation focused on the required case management services of (1) developing a comprehensive assessment, (2) developing a comprehensive care plan and (3) monitoring the services provided to the Elderly and Chronically Ill waiver program participants. A sample of cases was reviewed by a team comprised of staff from the Bureau of Elderly and Adult Services (BEAS) state office, the DCBCS Quality Leadership Team and BEAS Adult Protective Services field staff. The sample size for each agency was determined through the use of a statistical program used by the Bureau of Behavioral Health in its annual eligibility and quality assurance reviews.

Each case management agency received a report that included the results for each of the 38 questions and, when applicable, recommendations for improvement. The agencies were required to submit a quality improvement plan that addressed each recommendation within sixty days of the receipt of its program evaluation report.

BEAS also committed itself to its own quality improvement activity by reviewing the 2009 case management program evaluation process, protocol and review instrument. The results were a reduced number of questions from 38 to 21, the use of a statistical

application recommended by the National Quality Enterprise[1] consultants that identified a representative statewide sample for the SFY 2011 program evaluation, and the decision not to rate the timeliness and quality of initial assessments and initial care plans for those cases opened prior to the adoption of the rule, i.e., August 26, 2008, for the SFY 2011 program evaluations.

The protocol and instrument included a four point rating scale, as indicated below:

0	Not applicable, e.g., activity occurred prior to effective date of applicable rule
1	Does not meet minimal expectations, e.g., documentation is missing
2	Meets minimal expectations as established and described in rule
3	Exceeds minimal expectations, i.e., example of best practice

The goal for the initial case management program evaluation was to complete an evaluation on all five of the case management agencies within a few weeks in order to establish a baseline for each agency and for case management for the CFI waiver program as a whole. Going forward, it is anticipated that a complete case management program evaluation will be held annually with each agency that provides case management services to CFI participants. It is anticipated the program evaluation protocols will expand to address additional components of the Targeted Case Management rule, include other pertinent questions and a financial component. These are the goals of the 2010-2011 BEAS Case Management Program Evaluation scheduled bi-monthly from September 2010 through April 2011.

[1] The National Home and Community-Based Services Quality Enterprise (NQE) provides technical assistance on quality to state Medicaid home and community-based services programs (HCBS) and to federal government staff responsible for overseeing these programs.

The NQE is funded by the Centers for Medicare and Medicaid Services (CMS.) under a grant to the Healthcare Business of Thomson Reuters. Professionals from Thomson Reuters and the Human Services Research Institute staff the NQE, along with consultants from other organizations.

Scope and Methodology

A report of participants in the Choices for Independence program as of the end of August 2010 was run which included cases that had been open for at least six months to allow time for a comprehensive assessment, a comprehensive case plan and for services to have been provided for at least a few months. Cases that were closed but had been closed for six months or less as of the end of August 2010 were also included.

A statistical application was used to identify a randomized and representative statewide sample that would yield a 5% confidence interval at the 95% confidence level. A proportionate sample was identified for each case management agency based on the statewide sample. See chart below:

	CFI population (as of the end of Aug. '10)	Statewide representative sample (5% confidence interval; 95% confidence level)	Proportionate sample of Crotched Mountain Community Care cases
Crotched Mountain Community Care	796		106
Total population	2510	333	

The list of cases was distributed to Crotched Mountain Community Care approximately three weeks prior to its scheduled state fiscal year 2011case management program evaluation. The program evaluation began with a brief meeting that included introductions, review of the evaluation schedule and an introduction to CMCC's case record documentation system.

The program evaluation was completed in three days which included an exit meeting where reviewers' observations regarding the cases they reviewed were shared along with informal consultation regarding the agency's documentation system and case practice. The exit meeting included Crotched Mountain Community Care's management team and several members of the program evaluation team.

The program evaluation instrument was based on the three sections of the Targeted Case Management rule, i.e., He-E 805, as discussed in the Executive Summary. The program evaluation process, as was emphasized, is a quality management / quality improvement process with the expectation that each agency would produce a quality improvement plan that includes "the remedial action taken and/or planned including the date(s) action was taken or will be taken."[2]

[2] He-M 805.10(b)(4)

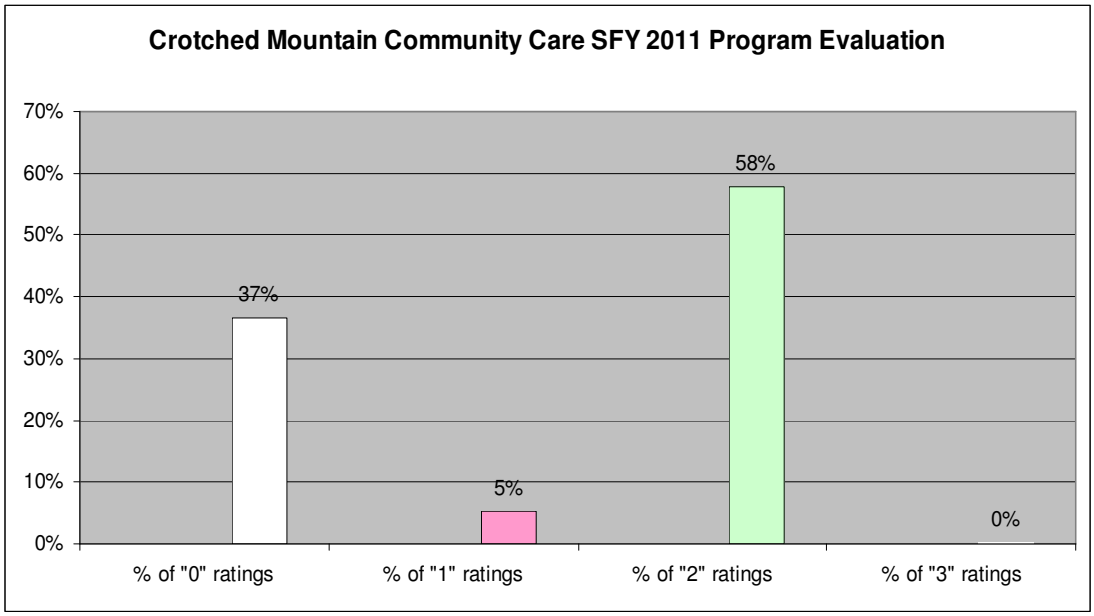
Findings and Observations

Preliminary observations were shared with CMCC at the exit meeting held at the end of the program evaluation.

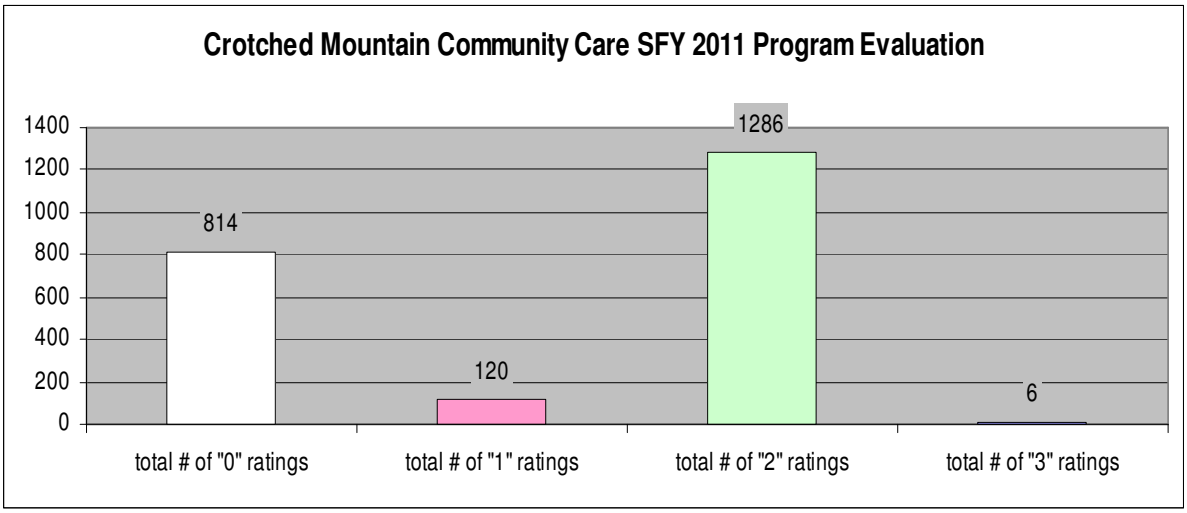
It was not possible to have gathered and assessed the data from all the case reviews for the exit meeting; the observations shared with the agency staff were a result of the daily and final wrap-up conversations with the program evaluation reviewers.

The ratings for each of the 20[3] questions are presented within the appropriate section of the report. Four questions[4] were rated for timeliness with one rated for both timeliness and quality (question #22) for a grand total of 21 ratings for each of the 106 cases.

Below and on the next page are two charts that illustrate the rating results with the majority of questions (58%) (1286) being rated as meeting minimal expectations, i.e., rating of "2", regarding the items in the He-E 805 Targeted Case Management rule. Five percent (120), of the total questions were rated as not meeting minimal expectations (rating of "1"), e.g., documentation is missing. Zero percent (6) of the total questions were rated as exceeding minimal expectations (rating of "3"), e.g. best practice.



[3] The Case Management Program Evaluation instrument was revised with several questions combined for a total of 21 questions for SFY 2011; there were 38 questions in the CY 2009's program evaluations.
[4] Questions #1, 11, 19 and 22.



Two questions addressing timeliness were rated as zero, indicating not applicable, when the items in question were developed prior to the August 2008 adoption of the Targeted Case Management Rule, He-E 805, and thus could not legitimately be rated. Ratings of zero were recorded for the following questions when a Choices for Independence case was opened prior to August 2008:

#	BEAS Case Management Program Evaluation
1	Comprehensive Assessment is conducted within 15 working days of assignment
11	Care Plan is developed within 20 working days of assignment

The majority (76 or 72%) of the 106 cases reviewed were opened prior to the adoption of the He-E 805 rule with 30 (28%) opened after the adoption of the rule.

A zero rating was also recorded by the team leader when it was impossible to determine the reviewer's intent when an item was not rated or the rating appeared to be grossly inconsistent with ratings on related questions.

Reviewers were encouraged to include explanatory and helpful comments as they reviewed the cases; a table of their comments, categorized as indicators of "challenges/concerns" and "positive practices" are included in the appendix of this report.

Comparison with CY 2009 Program Evaluation

The June 2009 Crotched Mountain Community Care program evaluation results were similar to the September 2010 program evaluation results except for the number and percent of "0" ratings which, of course, effected the other ratings.

	CY 09	SFY 11
count of 0 ratings	279	814
count of 1 ratings	221	120
count of 2 ratings	2781	1286
count of 3 ratings	51	6
totals	3332	2226

	CY 09	SFY 11
% of 0 ratings	8%	37%
% of 1 ratings	7%	5%
% of 2 ratings	83%	58%
% of 3 ratings	2%	0%
totals	100%	100%

The CY 09 program evaluation reviewed 68 cases; the SFY 11 program evaluation sample was 106 cases one of which was not completed in error resulting in 105 cases reviewed. The comprehensive assessment (questions # 1-9) and timeliness of the initial case plan (#11) were erroneously not rated in three cases that were actually opened after the rule was adopted; zero ratings were entered for these cases.

The CY 09 program evaluation included 39 questions; the SFY 11 program evaluation included 21 questions by combining related questions and eliminating others that were determined not to be necessary.

The CY 09 program evaluation included 11 questions that were rated for both timeliness and quality (#19, 20, 21, 29, 30, 31, 33, 35, 36, 37, 38); the SFY 11 program evaluation included 1 question that rated both timeliness and quality (# 22).

The change in the SFY 11 program evaluation to not rate the comprehensive assessment questions (#1, 2, 3, 4, 5, 6, 7, 8 and 9) when cases were opened before the approval of the Targeted Case Management rule (He-E 805) resulted in more questions rated as zero and fewer rated as two.

The SFY 11 questions included five that were a combination of two or more questions from the CY 09 program evaluation and seven that were removed. See the appendix for the SFY 2011 program evaluation instrument.

	SFY 2011
1	Same question as CY 09
2	Same
3	Same
4	Same
5	Same
6	Same
7	Same
8	Same
9	Combined with #10
10	See #9
11	Same
12	Removed
13	Same
14	Combined with #15 and #33
15	See #14
16	Combined with #17
17	See #16
18	Same
19	Same
20	See #24
21	See #22
22	Combined with #21, 23, 32 and 38
23	See #21
24	Combined with # 20, 27 and 35
25	Same
26	Removed
27	See #24
28	Misnumbering; no #28
29	Same
30	Same
31	Removed
32	See #22
33	See #14
34	Removed
35	See #24
36	Removed
37	Removed
38	See #22
39	Removed

The SFY 2011 program evaluation included a review of the status of each agency's recommendations from its CY 2009 program evaluation and of the agency's policies and practices regarding BEAS state registry regulations.[5]

Recommendations

Based on the ratings and reviewer observations and comments, two recommendations were made for Crotched Mountain Community Care to address in its quality improvement plan.

Comprehensive Assessment (questions #1-9)

The protocol the reviewers followed was to rate all the questions in this section only if the cases were opened on or after the rule was adopted in late August 2008.

	Questions								
	1	2	3	4	5	6	7	8	9
count of (0) ratings	80	80	80	80	80	80	80	80	80
count of (1) ratings	0	0	1	1	0	0	1	4	3
count of (2) ratings	26	26	25	25	26	26	25	22	23
count of (3) ratings	0	0	0	0	0	0	0	0	0
Total	106	106	106	106	106	106	106	106	106

This section assessed the timeliness of completing the initial comprehensive assessment (question #1) and whether each required section was adequately addressed. The comprehensive assessment is required to address a client's biopsychosocial history (#2), functional ability (#3), living environment (#4), social environment (#5) self-awareness (#6), assessment of risk (#7), legal status (#8) and community participation (#9).

CMCC, Inc's *Client Assessment* instrument's content meets the requirement of He-E 805 and the vast majority were complete and well done.

When the "0" ratings (80) are eliminated from the total records reviewed (106), four records were rated as "1", not meeting minimal standards, for question #8 and three records for question #9. The four records for question #8 are 15% of the total records with ratings of "1", "2" or "3" (27); the three records for question #9 are 12%. CMCC should monitor the comprehensiveness of its assessments as some did not address legal

[5] He-E 805.04(c): Case manasgement agencies shall establish and maintain agency written policies and procedures regarding the following areas, and ahall ensure that they are properly followed and enforced: (2) a process for confirming that each employee is not on the BEAS state registry established pursuant to RSA 161-F:49.

status and some did not explore or document clients' interests and desires regarding their community connections.

Though the agency's *Client Assessment* form includes all the required components, the Abuse/Neglect Status provides limited information. It includes a checklist of types of abuse or neglect and a "not applicable" check box. CMCC is encouraged to change this to "not observed", or "no evidence" and encouraged to have staff provide information about each abuse/neglect status checked.

CMCC Recommendation #1
CMCC should provide training, enhance its supervison practices and/or more closely monitor the quality and completeness of its initial comprehensive assessments to ensure that the legal status and community participation of each client are addressed.

Development of Care Plan (questions #11-19)

	Questions					
	11	13	14	16	18	19
count of (0) ratings	78	1	1	1	1	4
count of (1) ratings	0	85	0	2	19	0
count of (2) ratings	28	20	105	103	82	102
count of (3) ratings	0	0	0	0	4	0
Total	106	106	106	106	106	106

This section addressed:

- the timeliness of developing the initial (#11) and annual care plans (#19),
- whether care plans included client-specific measureable objectives and goals with timeframes (#13),
- whether care plans contained all the services and supports needed (#14),
- whether care plans addressed mitigating any risks for abuse, neglect, self-negect and exploitation (#16), and
- whether care plans included contingency planning (#18).

Reviewers rated questions #13 through #18 based on the most current care plan which would be the initial care plan for cases opened less than a year or the most recent annually updated care plan for cases opened a year or more.

This section of questions proved to be the most challenging for CMCC particularly question #13 and less so #18.

- Eighty percent (85) of the cases for question #13 were rated as one, does not meet minimal expectations, with only nineteen percent (20) of the cases rated as two, meets minimal expectations.
- Eighteen percent (19) of the cases for question #18 were rated as not meeting minimal expectations, with seventy-seven percent (82) of the cases rated as meeting minimal expectations. These results are adequate but in combination with the poor results for question #13, CMCC is encouraged to include contingency planning when reworking its care plan development policy.

The Reviewer Comments' section includes many examples from the cases reviewed of objectives that could have been included in the care plans and written as measurable and with timeframes. The goal of "to remain living independently in my own home/community" is fine as an individual's primary goal, but an individual's care plan must include the specific short and/or long-term objectives necessary to maintain that goal and the client's maximum health, safety and well-being.

The *Total Plan of Care* form is comprehensive as it is designed to include Medicaid state plan and unpaid services in addition to waiver services. Reviewers found CMCC staff resourceful as there was evidence of staff seeking outside resources including through fund-raising to meet, for example, dental needs and home modifications.

CMCC's *Emergency Assessment* is a good tool to inform contingency planning however, sometimes it was barely completed with little to no evidence of planning and, conversely, there were several examples of good planning. CMCC is encouraged to read the Reviewer Comments' section for examples of both good practice and practice that is in need of improvement.

CMCC is encouraged to consider differentiating between unmet needs, i.e., needs that cannot be met due to resources being unavailable or undeveloped, and gaps in services, i.e., a short-term break in existing resources such as a waiting list for community mental health services. BEAS suggests that this differentiation would be useful in community needs assessments, et. al.

Though the current rule does not require that clients are given a copy of their initial and annual case plans, CMCC is encouraged to consider adopting this practice rather than providing copies only when requested to do so.

<u>CMCC Recommendation #2</u>:
CMCC should review its policy and practice regarding developing care plans, provide training, enhance its supervision practices and/or more closely monitor the quality and completeness of its care plans to ensure that care plans:

1. contain client-specific, measurable objectives and goals with timeframes;
2. contain comprehensive contingency plans that address alternative staffing and special evacuation needs.

Since CMCC has not demonstrated improvement from the 2009 Program Evaluation[6] regarding question #13, CMCC is expected to enhance its monitoring of clients' care plans to ensure that they meet the criteria addressed in He-E 805.05(c) through its quality management record review process as described in He-E 805.10.

III. Monitoring and Evaluation of the Care Plan (questions #22-25)

	22T	22Q	24	25
count of (0) ratings	2	1	1	2
count of (1) ratings	1	1	1	0
count of (2) ratings	103	103	104	103
count of (3) ratings	0	1	0	1
Total	106	106	106	106

Reviewers rated contact and progress notes during the period under review, between September 30, 2009 and October 11, 2010, but focused primarily on the most current six months, i.e., April 2010 through early October 2010.

This section included three questions:

- the timeliness (#22T) and adequacy of contacts with clients, providers and/or family members (#22G);
- whether services were adequate, appropriate and provided (#24); and
- whether there was evidence that the client was actively engaged in his/her care plan and the case manager was making efforts to engage his/her client (#25).

This section is a strength for CMCC as its performance on almost 100% of the cases was that expectations were met. There are several positive practices noted in the Reviewer Comments section including case managers sending letters to clients without phones and calling clients with phones to remind them of their scheduled case management visits.

Reviewers commented that, in most cases, it was easy to determine clients' statuses and courses of action through reading progress notes and were impressed when some case managers followed the agency's extensive formal progress note format for documenting phone calls.

There are no recommendations for CMCC regarding the monitoring and evaluation of the care plan section of the program evaluation.

[6] Question #13 results were 76% rated as not meeting expectations in 2009 and 80% in 2011

IV. Provider Agency Requirements/Individual Case Record (questions # 29-30)

			29	30
count of (0) ratings			1	1
count of (1) ratings			1	0
count of (2) ratings			104	105
count of (3) ratings			0	0
Total			106	106

This section is also a strength for CMCC as its performance is that, except for one case for question #29, expectations were met for both questions in this section.

The reviewers noted that CMCC's *Client Information Card* was updated when needed though suggested including the date on the form when it was modified and/or reviewed.

There are no recommendations for CMCC regarding the case record requirement section of the program evaluation.

Quality Management and State Registry

CMCC had six recommendations as a result of its CY 2009 Program Evaluation, they were that CMCC was encouraged to:

1. review the quality of contingency planning so that it is as comprehensive and specific as it needs to be for each case;
2. adopt a policy that, on at minimum an annual basis, the care plan form, documents the review and status of every objective, the quality and appropriateness of every service to determine whether an individual's needs are being met, and the status of any unfulfilled need(s) and any gap(s) in needed service(s);
3. provide training on contingency planning and to focus on what constitutes adequate contingency planning;
4. record the discussions and outcomes of the periodic case monitoring meetings with other providers in clients' case records, to obtain copies of other providers' care plans and to do so on at least an annual basis to coincide with the annual care plan update;
5. document clients' Medicaid redetermination and whether their clients are prepared and, if not, what steps the case managers will take to ensure that preparations for redeterminations are adequate and that deadlines are met; and

6. review its procedures regarding requesting relevant correspondence from clients' other providers to ensure that pertinent information is obtained and maintained in its clients' case records.

CMCC's *Quality Assurance / Supervision Review* process and form addresses each of the six recommendations and that each team includes peer supervision twice a month where problems and questions are addressed. Recommendation #6 does not address a requirement of the He-E 805 rule; the question was included in the program evaluation as "information only" and thus the resulting recommendation was optional for CMCC to address. CMCC also submits quarterly quality management reports, as required per He-E 805.10(a) and (b), that summarize the results of case record reviews and remedial action taken to address identified deficiencies.

CMCC follows its parent organization's personel policies for new employees which includes performing criminal background and BEAS state registry checks per BEAS regulations and policies.

Conclusions / Next Steps

DCBCS and BEAS appreciate the opportunity to visit the Crotched Mountain Community Care agency and to gather information through a review of a number of the agency's case records. DCBCS and BEAS acknowledge that by hosting this program evaluation, CMCC spent valuable work time gathering case records, being accessible for questions, and attending the initial and exit meetings with the program evaluation team. CMCC staff were also gracious and provided the program evaluation team with use of its conference room which was very much appreciated.

The 2010/2011 program evaluation is the second designed to review the Targeted Case Management rule, He-E 805, and proved to be another valuable exercise as DCBCS and BEAS continue to work internally and with their stakeholders to improve the quality of the Choices for Independence waiver program and to successfully meet the assurances and subassurances required by the Center for Medicare and Medicaid Services (CMS) of its home and community based care waiver programs for the elderly and chronically ill.[7]

CMCC is expected to develop a quality improvement plan that includes the remedial action taken and/or planned including the date(s) action was taken or will be taken. The quality improvement plan should be submitted to DCBCS Quality Management at 129 Pleasant Street, Concord NH 03301 within sixty days of the receipt of this report.

[7] See the Appendix for the list of CMS Waiver Assurances and Subassurances

Appendices

Case Management Program Evaluation – Review Instrument

Reviewers' Comments / Observations

CMS (1915c) Waiver Assurances and Subassurances

Abbreviations

Case Management Program Evaluation – Review Instrument

Face Sheet

Case Management Agency

Name:
Address:
City/town:

Participant Name

First: Middle initial
Last:

Participant (current) Living Arrangement

☐ own home
☐ adult family home
☐ assisted living facility (name of facility):
Check if client resides in one of these facilities: ☐ Meeting House ☐ Whitaker Place ☐ Summercrest
☐ congregate housing
☐ hospital (name of hospital):
☐ nursing facility (name of facility):
☐ residential care facility (name of facility):
☐ other:

Case Information

Participant's Medicaid #:
Participant's date-of-birth:
Participant's (current) Case Manager:
Date of referral to Case Management agency:
Date Case Management case closed:
Reason for case closure:

Program Evaluation Information:

Period under review (from previous annual program evaluation to date of current evaluation): to
Date of Review:
Reviewer First: Last: Agency / Position:

Findings / Ratings (enter # in white (un-filled) boxes)	
1	does not meet minimal expectations, e.g., documentation is missing
2	meets minimal expectations as established in rules
3	exceeds minimal expectations, i.e., example of best practice
0	does not apply

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
805.05(b)		**I.** Comprehensive Assessment (builds on MED, needs list, support plan)			
805.05(b)	1	Comprehensive assessment is conducted within 15 working days of assignment Include date comprehensive assessment completed.	☐		
805.02(b) and 805.05(b)(2)(a)	2	Biopsychosocial history that addresses: • Physical health • Psychological health • Decision-making ability • Social environment (addressed in question #5) • Family relationships • Financial consideratins • Employment • Avocational interests, activities, including spiritual • Any other area of significance in the participant's life (substance abuse, behavioral health, development disability, and legal systems)		☐	
805.05(b)(2)(b)	3	Functional ability including ADLs and IADLs		☐	
805.05(b)(2)(c)	4	Living environment including participant's in-home mobility, accessibility, safety		☐	

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
805.05(b)(2)(d)	5	Social environment including social/informal relationships, supports, activities, avocational & spiritual interests		☐	
805.05(b)(2)(e)	6	Self-awareness including whether participant is aware of his/her medical condition(s), treatment(s), medication(s)		☐	
805.05(b)(2)(f)	7	Risk including potential for abuse, neglect or exploitation by self or others; identify whether a separate Risk Assessment has been completed		☐	
805.05(b)(2)(g)	8	Legal status including guardianship, legal system involvement, advance directives such as DPOA		☐	
805.05(b)(2)(h)(i)	9 (and 10)	Community participation including the client's need or expressed desire to access specific resources such as the library, educational programs, restaurants, shopping, medical providers and any other area identified by the client as being important to his/her lfe.		☐	
805.05(c)		**II.** Development of Care Plan			
805.05(c)	11	Initial Care Plan is developed within 20 working days of assignment	☐		
805.05(c)(1)	12	▪ Removed.			
805.05(c)(2)	13	▪ contains client-specific measureable objectives and goals with timeframes [review most current care plan]		☐	

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
805.05(c)(3)(a),(b)and (c) and 10-25 GM 5.14.10, and 10-30 GM 7.16.10, and 10-34 GM 7.30.10[8]	14 (and 15 and 33)	▪ contains all the services and supports based on the clients' needs in order to remain in the community and as identified in the comprehensive assessment and MED ▪ paid[9] services (identify) b) non-paid services (identify) c) enrolled in Medicare, Part D, if appropriate *(continued on next page)* d) maximize approved Medicaid state plan services before utilizing waiver services e) identify unfulfilled needs and gaps in services f) if pertinent, has there been consultation with an agency (community mental health center, area agency, etc) regarding diagnosis and treatment [evaluate most current care plan]		☐	
805.05(c)(3)(d) and (e)	16 (and 17)	Risks for abuse, neglect including self-neglect or exploitation and plan for mitigating existing risk(s) Issues identified via sentinel event reporting: • clients smoking while on oxygen • abuse (assaults) • medication abuse [evaluate most current care plan]		☐	

[8] Ensure that homemaker services (HCSP) are not actually personal care (HHCP) and that spouses are not providers
[9] Includes all paid services to be provided under Medicaid, including Medicaid state plan services, or other funding sources.

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
805.05(c)(3)(f), 805.02(l)	18	Contingency plan; the plan that addresses unexpected situations that could jeopardize the client's health or welfare, and which: • identifies alternative staffing • addresses special evacuation needs)		☐	
805.05(c)(4)(a) and, 10-17 GM 4.14.10[10]	19	Care Plan is updated: • annually, and • in conjunction with annual MED redetermination [evaluate most current care plan]		☐	Date of care plan reviewed:
805.05(d)		**III.** Monitoring and Evaluation of Care Plan[11]			
805.05(d)(1)(a) and (b) 2009 CM Program Evaluation Summary Report	22 (and 21, 23, 32 and 38)	No less than one monthly telephone contact and one face-to-face contact every 60 days. *(continue on next page)* Contacts notes with the client, other providers, and/or family members, should be frequent enough to adequately address the client's needs including readiness for annual Medicaid redetermination; location and type of contact (phone, face-face) should be specified. Describe frequency of contacts and with whom.	☐	☐	
805.05(d)(2); and 805.04(f)(7) 10-25 GM 5.14.10[12]	24 (and 20, 27 and 35)	Services are adequate, appropriate, provided as evidenced by: ○ CM agency Care Plan (see ques. #14, 16, 18, 19) ○ CM agency contact notes required for each client ○ Progress notes that reflect areas contained in the care plan, including authorizations for new or changed services		☐	

[10] Annual redetermination of medical eligibility for the CFI program includes review of the client's needs and process to authorize services
[11] Current terminology: MED process includes development of "service plans" by BEAS Long Term Care Nurse; Case Management agencies develop "care plans"
[12] Per 10-25 GM 5.14.10 (05/14/10): CM must "document types and amount of: home health services, personal care, physical care, physical therapy, occupational therapy, speech therapy, adult medical day, private duty nursing

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
805.05(d)(3)	25	Participant is actively engaged in care plan – and case manager is making adequate and appropriate efforts to engage the participant (see contact and progress notes, e-mails and correspondence with clients and providers, notes re case specific meetings with providers)		☐	
805.05(d)(4)	26	Removed			
	28	Instrument misnumbered with #28 overlooked			
805.04		Provider Agency Requirements			
805.04(f) 10-25 GM 5.14.10		**IV. Case management agencies shall maintain an individual case record which includes**:			
805.04(f)(1)	29	Face sheet including current (updated annually with the Care Plan and MED (see #19)) demographic and other information: name, DOB, address, Medicaid #, emergency contact person, phone number, address.		☐	
805.04(f)(2)	n/a	Comprehensive assessment (see 805.05(b))			
805.04(f)(3)	n/a	Care plan (see 805.05(c))			
805.04(f)(4)	30	Current MED needs list/support plan		☐	
805.04(f)(5)	31	Removed			
805.04(f)(6)	34	Removed			
805.04(f)(8)		Contact notes (see 805.05(d)(1))			
Information only	36	Removed.			
Information only	37	Removed			
805.04(f)(10)	39	Removed			

Total questions: 21

General Observations
Include observations pertinent to the case reviewed that have not otherwise been captured by the questionnaire and that would be useful to record as evidence of best practice and/or evidence of challenges to providing effective, appropriate and quality services.

Program Evaluation Completed: Date:
Name:

Quality Management
Program Evaluation Reviewed: Date:
Name:

Original Filed: DCBCS Quality Management
Copy: BEAS Quality Management

Reviewers Comments / Observations

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
I. Comprehensive Assessment			
1	Comprehensive assessment is conducted within 15 working days		
2	Biopsychosocial history		Very comprehensive
3	Functional ability, including ADLs and IADLs	Notation that client needs help with all ADLs but no further information available	
4	Living environment		
5	Social environment		
6	Self-awareness		
7	Risk, including potential for abuse, neglect or exploitation by self or others	Assessment states "unsafe neighborhood" but no further explanation or what action might be taken.	Very well documented
8	Legal status	• not addressed (3) • incomplete	
9	Community participation	• Noted that due to lack of transport, client does not participate in the community; no information regarding what client's goals/interests are regarding her community. • Not addressed (2) • No evidence of exploring the client's desires rather the assessment was limited to	

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
		recording client's current status in this realm	
10	Address in #9		
II. Development of Care Plan			
11	Initial Care plan is developed within 20 working days of assignment		
12	Removed		
13	Care plan contains measurable objectives and goals with timeframes	• Only goal is to remain independent in the community. No other details. • Care plan does not include measurable, goals and objectives or timeframes (74), e.g., "to remain living independently in my own home/community" is not client-specific or measurable and does not include a timeframe(s) o Example: one client with this goal had his electricity shut off 3 times in the year due to non-payment; this issue should become an objective with action steps and timeframes so client can sustain his community independence o Example: client needs portable ramp; family is pursuing. Target date: ___	• *Total Plan of Care* lists services • Each of the goals was measurable and with specific timeframes (2) • Very well documented. Goals and gaps change as client's needs change. Goals are client-oriented with timeframes and action steps to achieve the goals.

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
		○ Example: client needs additional funding for pool membership; case manager to research funding opportunities. Target date: ____ ○ Example: CM to follow up with RN about client's breathing status and determine if MD visit is needed. Target date:____ ○ Example: CM will work with client re: money management and financial needs. Target date:____ ○ Example: client needed nutrition information/counseling. Target date:____ ○ Example: client needs dentures; client in res care. Need to determine how this need is met with Target date. ○ Example: client needs bariatric shower bench and home modifications (need to be specific). Target date:____	

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
		• Objectives should not just be what the case manager will do next, eg CM to monitor client's inhome supports and services • Goals and objectives are generic not individualized (1), eg. "to remain living independently in my own home/community" • "Client maintains her independence in her home with CFI services"- another example of not being client-specific and lacking timeframes. • Goal was to remain in the community however, throughout the case record, CM was pursuing placement with client. • Goal was to remain "living independently in the community" though client is in res care • "CM will monitor care plan to ensure client has support needed to remain independent": lacks specificity of supports needed, client-specific objectives and timeframes	

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
14 (and 15 and 33)	Care plan contains all the services and supports based on the participants' needs in order to remain in the community and as identified in the comprehensive assessment and MED a) Paid services (identify) b) Non-paid services (identify) c) Enrolled in Mediare, Part D, if appropriate d) Maximize approved Medicaid state plan services e) Identify unfulfilled needs and gaps in services f) Consultation re diagnosis and treatment, if pertinent	• No evidence that client's request to be able to get outdoors being addressed. • Client's mental health needs (counseling, day program) not addressed in care plan • Medicare funded services not recorded on *Total Plan of Care* after client had kidney transplant (though well-documented in progress notes)	• No gaps in services noted (5) • *Client Assessment* form lists current provider and funding resources • Transportation identified as unmet need (2) • Client needs mental health and drug counseling; record reflects client's refusal and ongoing assessment and encouragement. • Includes in-kind, waiver services and those funded by Medicare. • Included church as informal support. • Unfulfilled needs and gaps identified and plan put in place to address them • Care plan is appropriate and supports are adequate • Res care client also has mental health services
15	Addressed in #14		
16 (and 17)	Risks for abuse, neglect including self-neglect or exploitation and plan for mitigating existing risk(s)	• Client's probable and current pain medication abuse should have been considered a risk. • Possible exploitation not addressed as several family members moved in and out of home leaving client	• Documented that risk is constantly being assessed (9) • Care Plan references the *Client Assessment* form where risk was initially assessed

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
		at risk of losing utilities as unable to pay bills. • Client exhibits drug-seeking behaviors, has stolen meds and is banned from local pharmacy; little discussion re mitigating self-neglect risk	• Well documented interventions (2) • CM called APS re self-neglect due to dementia; CM pursued activation of DPOA. • CM has been very proactive in matters related to exploitation. • Adequate note: "none reported or observed"
17	Addressed in #16		
18	Contingency plan addresses unexpected situations, identifies alternative staffing and special evacuation needs	• Contingency Plan identified on Care plan but nothing specific listed • Client lives with his family but a plan is not fully developed for his family's absence or if he has to leave the house (2) • "Client is resourceful" is not an adequate contingency plan • Contingency Plan is for individual to go to a shelter in an emergency; does not address staffing back-up plans or any evacuation needs • For the past year, documentation states that contingency planning is "not discussed" or "no plan" (2) • Plan states client will follow emergency plan of apartment	• Well addressed in annual care plan update/progress note. • Plan has evolved as client's condition has changed (rating of"3") • CM procured a generator for a client on oxygen • Good detail provided • Excellent contingency planning: CM monitored the issue of quality of care when caregiver was no longer able to care for elderly client; CM engaged family and found alternative housing (rated 3) • Comprehensive plan includes: lifeline to be used if at home, "911" to be used if in the

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
		complex and nothing more specific re client's use of wheelchair; nothing regarding alternative staffing • Emergency Assessment completed and noted need for followup as does not address back-up staffing or transportation needs should client need to evacuate to a shelter. • "Lives in senior housing and there are supports in place": not client-specific. • Back-up staffing addressed but no mention that fire department has been notified of client's use of oxygen (2) • Client's blindness not addressed. • Lacking back-up staffing planning. • Not addressed in annual care plan other than to write "no change" (3) • Record states that family members (mother, husband) would serve as back-up but plans do not specify in what capacity, whether they (the back-up family members) would be adequate; evacuation planning missing (2)	community, private home has fire evacuation plan, client to go to daughter's home in emergency (rated 3)

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
19	Care plan is updated: annually, and in conjunctiion w/annual MED	• Four areas of care plan not addressed (informal supports, ability for self-care, coping, back-up/contingency) other than to write "no change"	• Care plan updated in conjunction with MED redetermination
20	Addressed in #24		
21	Addressed in #22		
III. Monitoring and Evaluation of Care Plan			
22 (and 21, 23, 32 and 38)	No less than 1 monthly telephone contact and 1 face-to-face contact every 60 days	• Contact notes appear to be cut and pasted from one contact to another (1) • Face-to-face notes appear to be cut and pasted and lack specificity. • Contact is made with client every month but face-to-face visits are not occurring every other month • There were monthly contacts and one 4-month time period (in the year reviewed) with no face-to-face (rating: 2)	• Well documented followup with client (8) • At least 2 contacts each month with client • There was adequate, regular/ongoing contact • Though not addressed in Client Assessment, case manager did eventually engage client regarding her interest in community activities. • Agency has provided frequent and timely responses throughout many years of providing CM services. • CM has very frequent contacts and record indicates timely responsiveness to multiple and ongoing issues.

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
			• Res care client w/dementia seen monthly • Documentation of several contacts with providers, BEAS state office, provider team meetings • A monthly face-to-face visit could not occur; CM recorded reason why (CM had medical issue) (2)
23	Addressed in #22		
24 (and 20, 27 and 35)	Services are adequate, appropriate, provided as evidenced by: • CM agency Care Plan • CM agency contact notes • Progress notes	• Care plan includes lifeline but client's phone service has been disconnected for several months with no evidence of whether lifeline is still needed and, if so, what needs to happen to regain and maintain it.	• When the client's provider told the CM that more services were needed, the CM arranged for the appropriate services in a timely manner • CM's outreach clearly indicated with client that is hard to reach and who doesn't respond to voice mail or e-mail • Notes document that "client is satisfied with her plan of care and services" • Well documented contacts • Unmet needs are identified and client's refusal to pursue. • CM diligently follows up on client's questions and needs, eg

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
			grant application for vehicle repairs, research re Medicare Part D, follow-up on section 8 voucher
25	Participant is actively engaged in Care Plan	• There are inferences that the client is engaging with the case manager but the notes are weak	• Notes indicate client is happy with his caregivers. • Notes indicate client is actively involved in treatment (3) • CM engages well with client in spite of client's escalating dementia (2) • CM notified by DFA that Medicaid rede due; CM met w/client to assure process was completed (1) • Client is an active participant in her treatment (2)
26	Removed		
27	Addressed in #24		
28	Error in numbering		
IV. Provider Agency Requirements / Individual Case Records		• Emergency phone number included but not the name of the person who the number belongs to	
29	Face sheet	• Not all sections completed	
30	Current MED needs list / support plan		
31	Removed		
32	Addressed in question #22		
33	Addressed in question #14		
34	Removed		

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
35	Addressed in question #24		
36	Removed		
37	Removed		
38	Removed		
39	Removed		

General Observations	
Challenges / Concerns	**Positive practices**
Consider reframing the care plan in a more person-centered style. Instead of just listing the case management activities, identify the client's goals and, if realistic, what's needed in the care plan to achieve them.	Included a picture of the client in the case record
Example of short-term care plan goal that was not on care plan: client spoke about wanting to walk to local town library to get books but said she lacks the motivation to do so.	GSIL care plan included in case record. *GSIL Care Plan for Personal Services* is easy-to-understand format.
Client's home is not modified for a wheelchair and client needs new walker: two needs/objectives that should have been addressed on the care plan with specific steps and timeframes to achieve them.	Progress notes were detailed easily telling the "story" of the individual's care and care needs.
Annual care plan update re client in res care: "client told case manager she didn't know why she needed ECT treatments every month. Case manager told client to ask her doctor." No evidence of followup by case manager.	A number of case records are well documented.
The Abuse/Neglect Status section (4.D) of the *Client Assessment* could be expanded to require information about whether issue(s) were assessed (not just checked off) and whether or not the client is or is not at risk. It is unclear what the term "not applicable" means.	Documentation is very thorough re a difficult case to manage.
Client in assisted living facility has visits with case manager every other month; monthly phone calls are with staff and do not include client. No information whether client has access to a telephone	Client in res care "continues to have excellent support from her family." CM contacted client's daughter, client's guardian, to ensure Medicaid rede paperwork was complete.
Concern that client's PCA and PCSP are same person who is now on disability due to a medical condition but is still being paid as client's caregiver. Informal supports to help the PCA/PCSP were	

General Observations	
Challenges / Concerns	**Positive practices**
being provided part-time by a boarder in the home.	
Case manager did very good job working (and documenting) with client who continually makes poor choices re numerous concerns (house in disrepair, at risk for homelessness, at r isk of losing phone and electricity, lost lifeline, serious health issues). <u>However</u> there is concern about lack of evidence/documentation regarding the status of the client's needs and whether there has been follow through and/or progress made.	Case manager did very good job working (and documenting) with client who continually makes poor choices re numerous concerns (house in disrepair, at risk for homelessness, at risk of losing phone and electricity, lost lifeline, serious health issues).
Two months of face-to-face contacts missed for a client; documentation noted reasons included case manager was injured and off for 2 ½ weeks and office was being moved. No evidence of back-up plan for case manager's absence.	A difficult res care case, complicated by mental health issues and legal problems, was well handled by the case manager.

CMS (1915C) Waiver Assurances and Subassurances

Assurances	Subassurances	
Level of Care	Persons enrolled in the waiver have needs consistent with an institutional level of care	
	Subassurances	a. An evaluation for Level of Care (LOC) is provided to all applicants for whom there is reasonable indication that services may be needed in the future
		b. The levels of care of enrolled participants are re-evaluated at least annually or as specified in the approved waiver
		c. The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care
Service Plan	Participants have a service plan that is appropriate to their needs and that they receive the services/supports specified in the plan	
	Subassurances	a. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means
		b. The state monitors service plan development in accordance with its policies and procedures
		c. Service plans are updated / revised at least annually or when warranted by changes in the waiver participant's needs.
		d. Services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency specified in the service plan
		e. Participants are afforded choice: e.1. between waiver services and institutional care e.2. between / among waiver services, and e.3. providers

Assurances	**Subassurances**	
Qualified Providers	Waiver providers are qualified to deliver services / supports	
	Subassurances	a. The state verifies that providers, initially and continually, meet required licensure and / or certification standards and adhere to other standards prior to their furnishing waiver services
		b. The state monitors non-licensed / non-certified providers to assure adherence to waiver requirements
		c. The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.
Health and Welfare	Participants' health and welfare are safeguarded and monitored	
	Subassurance	The state, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.
Financial Accountability	Claims for waiver services are paid according to state payment methodologies	
	Subassurance	State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.
Administrative Authority	The State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for all facets of the program.	
	Subassurance	The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local / regional non-state agencies (if appropriate) and contracted entities.

Abbreviations

Abbreviation	Terminology
ADL	Activities of Daily Living
BEAS	Bureau of Elderly and Adult Services
CFI	Choices for independence program, formerly known as the Home and Community Based Care Services – Elderly and chronically Ill Waiver Program (HCBC-ECI)
CM	Case Management or Case Manager
CMCC	Crotched Mountain Community Care
CMS	Center for Medicare and Medicaid Services
CY	Calendar Year
DCBCS	Division of Community Based Care Services
DPOA	Durable Power of Attorney
HCBC – ECI	Home and Community Based Care Services – Elderly and Chronically Ill Waiver Program renamed the Choices for Independence program (CFI)
IADL	Instrumental Activities of Daily Living
LOC	Level of Care
NF	Nursing Facility
PCP	Primary Care Physician
PCA	Personal Care Attendant
PCSP	Personal Care Service Provider
PES	Participant Experience Survey
POC	Plan of Care
SFY	State Fiscal Year